Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

No significant changes

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Pennsylvania** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Medicaid Waiver for Infants, Toddlers and Families

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: PA.0324
Waiver Number:PA.0324.R05.00
Draft ID: PA.029.05.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/21

Approved Effective Date: 07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

ICF/IID and ICF/ORC categories are used for this waiver.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- [ ] **§1915(b)(1) (mandated enrollment to managed care)**
- [ ] **§1915(b)(2) (central broker)**
- [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
- [ ] **§1915(b)(4) (selective contracting/limit number of providers)**

- [ ] **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [ ] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Infants, Toddlers and Families (ITF) Waiver provides home and community-based services, specifically special instruction, to infants and toddlers, birth to age three who are experiencing developmental delay(s) as evidenced by a minimum of a 50 percent delay in one or a 33 percent delay in two developmental areas, and who need Early Intervention services per state regulations at 55 Pa. Code § 4226.23 (relating to Eligibility for Medicaid waiver services). Infants and toddlers served in this waiver would otherwise require institutional care in an Intermediate Care Facility for Persons with Intellectual Disabilities or other related conditions.

The waiver is operated by the State Office of Child Development and Early Learning (OCDEL), a separate division within the single state agency. OCDEL exercises administrative discretion in the administration and supervision of the waiver and issues rules, regulations, policies, and procedures related to the waiver. OCDEL monitors Infant Toddler Early Intervention programs' compliance with requirements for implementation of the waiver through formal monthly and annual data reviews from the statewide data system, PELICAN-EI, program or topic specific data reviews on a more frequent basis, as needed, during the Early Intervention verification process, and across training and technical assistance activities.

Infant Toddler Early Intervention programs are responsible for local implementation of the waiver pursuant to the Operating Agreement between OCDEL and Infant Toddler Early Intervention programs for services under the Medicaid Waiver for Infants, Toddlers and Families. The Operating Agreement specifies Infant Toddler Early Intervention program responsibilities related to eligible waiver service(s) and service provision; determination of initial eligibility for level of care and annual re-certification; development, approval and monitoring of the written Individualized Family Service Plan (IFSP); freedom of choice; provider participation; and financial administration.

Early Intervention waiver services are delivered by Early Interventionists pursuant to an individualized written plan of care, the IFSP, and in natural environments with the participation of the family or caregiver. The IFSP is developed by qualified individuals for each infant or toddler enrolled in this waiver. The IFSP describes the developmental, medical and other services and support (regardless of funding source) to be provided, their frequency, and the type of provider who will provide each service.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are

provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Pennsylvania secures public input in the development of the waiver application through a statewide stakeholder Early Intervention advisory group, Early Intervention leadership meetings, family leadership organizations, and through dissemination of information about the proposed application to Early Intervention parent and provider constituent groups. The use of multiple strategies allows the Bureau of Early Intervention Services and Family Supports (BEISFS) to gather statewide stakeholder input across all ages, geographic regions, roles in Early Intervention, and other interests related to Early Intervention.

Pennsylvania's primary Early Intervention stakeholder group is the State Interagency Coordinating Council (SICC). The SICC provides stakeholder input for both the Infant and Toddler and Preschool Early Intervention programs. The SICC typically meets face-to-face, but also uses webinar connections so that stakeholders who are unable to travel to meetings can still participate in discussions and decision-making. During Fiscal Year (FY) 2020-21, the SICC met virtually due to COVID-19 health and safety requirements. The Committee for Stakeholder Engagement (CSE), a workgroup of the SICC, focuses on the review of Early Intervention data and advises BEISFS on issues related to the coordination of the state's birth-5 Early Intervention system, including the ITF waiver.

Membership in the SICC and CSE is composed of parents (as co-chairs), Early Intervention service delivery agencies, a member of the General Assembly, local Early Intervention program administrators, and representatives from the Children's Health Insurance Program (CHIP), the American Academy of Pediatrics, higher education, early childhood education programs, and the Pennsylvania's Education for Children and Youth Experiencing Homelessness Program. Appointed designees from the Department of Human Services, Department of Health, and Department of Education also sit on the SICC and CSE. Additional CSE members include representatives from Parent Information and Advocacy Centers and the Early Intervention Providers Association.

Stakeholder input is gathered from families who have children enrolled in Early Intervention through outreach to Pennsylvania parent information and advocacy centers. These advocacy centers include: The PEAL Center, Hispanos Unidos Para Nino's Excepcionales (HUNE), and others. Input is also gathered from families who participate in Local Interagency Coordinating Councils (LICCs) and local Early Intervention advisory groups that play an advisory role that is similar to the SICC, but at a local level. OCDEL employs a Special Assistant on Family Engagement, whose expertise ensures input from family members.

BEISFS solicits public input related to Early Intervention policy and program implementation through regularly scheduled meetings with leaders from Infant, Toddler and Preschool Early Intervention programs. Bi-monthly Early Intervention Statewide Leadership meetings, organized by BEISFS, provide opportunities to communicate and clarify new and updated policies, and to gather input on proposed changes to existing policies and applications.

BEISFS meets regularly with other Early Intervention constituent groups, such as Pennsylvania Association of Intermediate Units and the County Commissioners Association of Pennsylvania. BEISFS engages in collaborative planning efforts across Early Intervention/Early Childhood with the governor-appointed Early Learning Council and the statewide Early Learning Resource Centers.

Pennsylvania began the public input process for at least 30-days and completed the process prior to the waiver submission to CMS. Pennsylvania's comment period began on 2/18/21 and closed on 3/26/21. The application was made available on the Pennsylvania DHS webpage, and via hard-copy both by request by sending email or calling the OCDEL main office. Additionally, the application was made available to stakeholders through local program distribution ensuring that the preferred contact method was used to reach all families. Preferred contact methods could include USPS, electronic-mail or web-based access. Several requests were received at the OCDEL main office for a paper-copy of the application demonstrating that individuals without computer access were reached. At the close of the comment period, no comments were received.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title

VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Kozak

First Name: Sally

Title: Deputy Secretary

Agency: Office of Medical Assistance Programs

Address: 625 Forster Street

Address 2:

City: Harrisburg

State: **Pennsylvania**

Zip: 17120

Phone: (717) 705-5007 **Ext:** ☐ **TTY**

Fax: (717) 346-9330

E-mail: sakozak@pa.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Parker

First Name: Lisa

Title: Director, Bureau of Early Intervention Services

Agency: Office of Child Development and Early Learning

Address: 333 Market Street Tower, 6th Floor

Address 2:

City:	Harrisburg
State:	**Pennsylvania**
Zip:	17126
Phone:	(717) 214-7130 **Ext:** ☐ **TTY**
Fax:	(717) 346-9330
E-mail:	liparker@pa.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Emily Hackleman
	State Medicaid Director or Designee
Submission Date:	May 25, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Parker
First Name:	Lisa
Title:	Director, Bureau of Early Intervention Services
Agency:	Office of Child Development & Early Learning
Address:	333 Market Street Tower, 6th Floor
Address 2:	
City:	Harrisburg

State: Pennsylvania

Zip: 17126

Phone: (717) 214-7130 **Ext:** ☐ **TTY**

Fax: (717) 346-9330

E-mail: liparker@pa.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The ITF Waiver serves infants and toddlers, birth to age three who are experiencing developmental delay(s) as evidenced by a minimum of a 50 percent delay in one developmental area or a 33 percent delay in two developmental areas, who need early intervention services and are eligible for an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID) or an Intermediate Care Facility for Persons with other Related Conditions (ICF/ORC) level of care.

Special instruction is the only service available under the ITF Waiver. Special instruction includes: designing the learning environment and activities that promote the acquisition of skills by an infant or toddler with a disability in a variety of developmental areas, including cognitive processes and social interaction; curriculum planning, including the planned interaction of personnel, materials and time and space, that leads to achieving the outcomes on the IFSP; providing the family with information, skills and support related to enhancing the skill development of the infant or toddler with a disability; working with the infant or toddler with a disability and family to enhance the infant or toddler's development.

Special instruction is delivered by early interventionists pursuant to an individually written plan of care, in natural environments with the participation of the family or caregiver. The child’s natural environment is primarily the child’s home, however, may also be in a community setting, such as a child care facility, park, or grocery store.

The OCDEL presumes that all waiver services provided in a private home meet the requirements of the CMS rule. Because the infants and toddlers served in the ITF Waiver live and receive services primarily in their own private homes, or in a community setting that is typical for the child's age peers, where children without a disability are likely to attend, OCDEL presumes that all services provided through this waiver meet the requirements of home and community-based settings and are compliant with the CMS rule. For this reason, no changes are needed to policies, regulations or waivers; no remediation strategies are necessary and no settings will be submitted for heightened scrutiny. OCDEL will continue to monitor waiver providers to ensure individuals continue to receive services in compliant settings. Ongoing monitoring for compliance is achieved through OCDEL’s annual verification process that is completed either through a verification visit or a self-verification completed by local programs utilizing standardized tools and procedures.

OCDEL issues a findings report for both verification visits and self-verification and infant/toddler early intervention programs develop a Quality Enhancement Plan (QEP) to address non-compliance. The QEP is required to be submitted within 30 days of receipt of the verification findings report. The QEP must address all areas of non-compliance and include activities designed to correct non-compliance within 365 days of the issuance of the verification findings report.

OCDEL approves the QEP. The state also conducts validation activities according to standard timelines to assure non-compliance is corrected by implementation of listed improvement activities within 365 days of issuance of findings report.

OCDEL assures that the above settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. OCDEL will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Office of Child Development and Early Learning

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Office of Child Development and Early Learning (OCDEL) is responsible for performing all functions related to the day-to-day administration and operation of the waiver, including 1) issuance of rules, regulations, policies and procedures; 2) execution of provider agreements; 3) development and implementation of an operating agreement with local infant/toddler Early Intervention programs; and 4) monitoring of infant/toddler Early Intervention programs.

The State Medicaid Director oversees OCDEL's administration and operation of the waiver through review of 1) the waiver application, including tracking of the application process and timelines, amendments and Request for Additional Information responses; 2) oversight of the State's Medicaid Management Information System; 3) 372 report submissions; 4) statements of policy and policy interpretations, bulletins, announcements, etc.; and 5) communications with the Centers for Medicare and Medicaid Services. The State Medicaid Director exercises authority and final decision making related to the waiver through this process.

The process utilized to outline the roles and responsibilities related to waiver operation includes, but is not limited to, memo routing and sign-off procedures to inform, track and obtain concurrence related to all aspects of OCDEL's administration and operation of the waiver.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus

this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Per the Medicaid Waiver Operating Agreement, infant/toddler Early Intervention programs have been delegated responsibilities to perform operational and administrative functions related to the approved waiver, including functions such as completing intake; determining level of care and continued level of care; and development, implementation and review of IFSPs and service coordination.

Infant/toddler Early Intervention programs may purchase fiscal and program administrative services as per the Medicaid Waiver Operating Agreement. When such services are purchased, the infant/toddler Early Intervention program retains responsibility for the function and compliance with the Medicaid Waiver Operating Agreement.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of Child Development and Early Learning; Bureau of Early Intervention Services and Family Supports.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Pennsylvania's oversight and general supervision of the state's 48 infant/toddler Early Intervention programs' compliance with requirements for implementation of the waiver and the provision of Early Intervention services occurs on an ongoing basis. The Office of Child Development & Early Learning; Bureau of Early Intervention Services and Family Supports (BEISFS) is supported by its contracted statewide training system, Early Intervention Technical Assistance (EITA), to provide ongoing training and technical assistance to infant/toddler Early Intervention programs.

There are four primary procedures used to assess the performance of each infant/toddler Early Intervention program: 1) assignment of a BEISFS advisor as a primary contact; 2) ongoing review of the statewide data; 3) participation in the verification process every four years; and 4) annual rating of program performance levels through the determination process.

Assignment of a Primary BEISFS Advisor
Each infant/toddler Early Intervention program is assigned a BEISFS advisor. The advisor serves as primary contact to the infant/toddler Early Intervention program and is responsible for addressing waiver concerns, budget issues, compliance issues, complaint issues, policy and procedural requirements and overall program performance.

The BEISFS advisor has ongoing contact with each of their local infant/toddler Early Intervention programs throughout the year. These contacts occur during the verification process, validation visits, training and technical assistance visits, complaint investigations, biannual leadership meetings and monthly local regional meetings. The assignment of a primary BEISFS advisor ensures that: 1) all BEISFS staff, advisors and statewide management staff are aware of program concerns and issues; 2) BEISFS has the ability to fulfill requirements for a comprehensive and effective general supervision system that identifies and addresses issues of noncompliance; 3) the correction of issues of noncompliance is completed within one year; and 4) improvement strategies and enforcement strategies are implemented in a timely manner.

Review of Statewide Data
Pennsylvania uses a comprehensive data management system, PELICAN, that enables the review of individual child data as well as statewide data. The data management system supports referral information, service coordination activities, planning information, financial management including waiver management, quality measures and other reporting needs for BEISFS. The data management system generates documents (Evaluation and Plan Documents). The information contained in these documents is used to create reports to manage the program.

The monthly, quarterly and annual data review includes review of specific waiver assurance data, including evaluation and re-evaluation for level of care, choice of community services or institutional care; timely service delivery; and annual plan development. The rigorous analysis of the data by staff allows BEISFS to ensure data driven decision making for quality improvement.

Verification Process
The verification process occurs every four years and focuses on a standard set of required indicators in each of the following areas: child find and public awareness; procedural safeguards; evaluation for eligibility; program planning; service delivery; transition; and fiscal and operational accountability. Each area includes indicators that focus on:

1. Compliance with state and federal regulations,
2. Assurances outlined in the waiver application; and
3. Program management to ensure continuous quality improvement.

Verification teams, including BEISFS and EITA staff are utilized during the verification process. The utilization of verification teams allows BEISFS to ensure interrater reliability.

The verification process includes the following standardized activities: data reviews, review of policies, individual child record reviews and observations of service delivery. Standard child record samples as well as targeted child record samples are utilized for the verification process. Both samples are randomly selected by BEISFS. A comprehensive review is completed on the standard child record sample. The targeted sample is pertinent to specific areas (ex., transition, ITF Waiver) and is designed to ensure that an adequate child record sample is obtained when reviewing specific requirements.

BEISFS issues a findings report for the verification process. Local infant/toddler Early Intervention programs develop Quality Enhancement Plans (QEPs). QEPs focus on addressing noncompliance issues, improvement needed in the area

of program management, and activities to enhance program quality to improve outcomes for children and families. The OCDEL approves all QEP activities and timelines.

The BEISFS advisor is responsible for validating that all areas of noncompliance, related to both individual child and systemic concerns, identified during the verification process are corrected as soon as possible, but no later than within one year of identification. Additional contacts from BEISFS staff may occur at the discretion of BEISFS if during the verification cycle there is a significant decrease in program performance or if individual or systemic concerns arise.

Determination Process
Pennsylvania's annual determination process uses evidence from the annual survey of families enrolled in Early Intervention, information received by BEISFS through the complaint resolution process, data from the monitoring of contracted agencies and providers, and PELICAN data elements, including compliance and data quality measures. The determination process provides a rating of meets requirements, needs assistance, needs intervention or needs substantial intervention across three areas: Strengthening Partnerships, Shared Leadership and Systemic Implementation of Evidence-Based Practices.

Based on the determination results, local infant/toddler Early Intervention programs update their QEP to reflect correction of noncompliance and improvement activities. The determination results are also used to provide differentiated levels of support to local infant/toddler Early Intervention programs. This allows the BEISFS to use resources in a more effective and efficient manner and have the greatest impact on program practices.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of providers delivering waiver funded services that have completed a provider agreement. Numerator = number of providers delivering waiver funded services that have completed a provider agreement. Denominator = all providers delivering waiver funded services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver provider agreements

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Individual problem(s) identified through the OCDEL's review of whether a provider has completed a provider agreement will be addressed with the provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	0	2	☐
	☒	Intellectual Disability	0	2	☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Infants and toddlers birth to the third birthday that need early intervention services as evidenced by a minimum of a fifty percent (50%) delay in one or thirty-three percent (33%) delay in two of the following developmental areas:

a. cognitive development
b. physical development, including vision and hearing
c. communication development
d. social and emotional development
e. adaptive development

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

In Pennsylvania, pursuant to Early Intervention Services regulations, 55 Pa. Code Chapter 4226, all infants or toddlers that are involved in the early intervention program are required to receive transition planning. The transition plan documents the activities the service coordinator, the family and team members will engage in to ensure effective transition for the child and family as they move onto the next step in the child's life. The transition planning process consists of a review of the child's service options, discussion with and training of parents regarding future supports and services, preparation of the child for changes in service delivery, and parental consent regarding transfer of information.

The following activities occur for infants or toddlers that are determined no longer eligible for waiver-funded services during the annual waiver re-certification process:
-The family is notified by the Service Coordinator that the infant or toddler is no longer eligible for waiver services.
-The family is notified of its fair hearing rights related to the eligibility determination.
-For the infant or toddler who continues to be eligible for early intervention services, services identified on the IFSP will continue as planned.
-If the child is no longer eligible for early intervention services, the appropriate transition planning will occur as discussed in paragraph #1 above to ensure that the child has a smooth transition to other community resources as needed.
-The County Assistance Office is notified that the infant or toddler is no longer eligible for waiver services.
-The County Assistance Office sends a notice to the family indicating that their child is no longer eligible for waiver services.
infant/toddler Early Intervention programs

For toddlers that become ineligible for waiver services because the child will be turning 3 years of age, the following activities occur:
-Infant/toddler Early Intervention programs notify families that the toddler is no longer eligible for waiver services because the child will be turning 3 years of age.
-The County Assistance Office is notified via the Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768) to discontinue eligibility for waiver services.
-The County Assistance Office sends a notice to the family indicating that the child is no longer eligible for waiver services 30 days prior to the child’s third birthday.
-Appropriate transition planning activities, discussed in paragraph #1 above, occur to ensure the child has a smooth transition to the preschool early intervention program or other appropriate community resources.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5300
Year 2	5600
Year 3	5900
Year 4	6200
Year 5	6500

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

In accordance with eligibility requirements described in the Eligibility for the Infants, Toddlers and Families Medicaid Waiver, Early Intervention announcement # EI-08-10, the waiver provides for entrance of all eligible children up to the maximum number approved by the Centers for Medicare and Medicaid Services. Entry to the waiver is offered to eligible infants and toddlers based on the date of their application for the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (●) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

All other mandatory and optional groups under the state plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**

(*select one*):

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:
- ( ) **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Qualified Professionals

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Initial evaluations are performed by qualified intellectual disabilities professionals, referred to as qualified professionals (QP), who have 1) at least one year of experience working directly with persons with intellectual or other developmental disabilities; and 2) is one of the following: a) a doctor of medicine or osteopathy, b) registered nurse, or c) an individual who holds at least a bachelor's degree in one of the following professional categories: 1) occupational therapist, 2) physical therapist, 3) psychologist, 4) social worker, 5) professional recreation staff person with at least a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education, 6) dietitian who is eligible for registration by the American Dietetics Association, 7) speech-language pathologist or audiologist, 8) other human services professional with at least a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling or psychology.

The QP must be licensed, certified, or registered, as applicable, to provide professional services by the state in which he/she practices. The Commonwealth of Pennsylvania does not currently license professional recreational staff person(s) or human services professional(s).

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria for an ICF/IID or ICF/ORC level of care for infants and toddlers up to the age of three are as follows:
1.a. A licensed psychologist, certified school psychologist or a licensed physician shall certify that the applicant or recipient has significantly sub-average intellectual functioning that is documented by one of the following:
(i) Performance that is more than two standard deviations below the mean as measurable on a standardized intelligence test.
(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized intelligence test during a period when the infant or toddler manifests serious impairments of adaptive behavior.
OR
1.b. A qualified professional shall certify that the infant or toddler has other related conditions as defined by 42 CFR 435.1010 that include cerebral palsy and epilepsy, as well as other conditions, such as, autism, other than mental illness, that result in impairments of general intellectual functioning or adaptive behavior, and require early intervention services and treatment.
AND
II. A qualified professional as defined in 42 CFR 483.430 certifies that the infant or toddler has impairments in adaptive behavior as provided by an assessment or adaptive functioning which shows that the applicant or recipient has one of the following:
(i) significant limitations in meeting the standards of maturation, learning, personal independence, or social responsibility of his/her age and cultural group evidenced by a minimum of a fifty (50) percent delay in one or thirty-three (33) percent delay in two of the following developmental areas:
(a) cognitive development
(b) physical development including vision and hearing
(c) communication development
(d) social and emotional development
(e) adaptive development
OR
(ii) substantial functional limitation in three or more of the following areas of major life activities:
(a) self-care
(b) receptive and expressive language
(c) learning
(d) mobility
(e) self-direction
(f) capacity for independent living
(g) economic self-sufficiency
AND
III. The applicant's or recipient's conditions are likely to continue indefinitely or for a period of at least 12 months.

The form used to certify level of care is the PW-123 and the re-certification form is the PW-123 A. The Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768) is used to communicate the infant/toddler program's eligibility determination to County Assistance Offices (CAO).

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The target population served under the Infants, Toddlers and Families Waiver is a narrow age range of infants and toddlers, birth to the third birthday, and is not the typical waiver population. A health assessment form that includes the same information as the MA-51, the level of care assessment form for institutional care, is used to confirm that the early intervention services that the infant/toddler needs are medically necessary. This medical assessment form is used in conjunction with the PW-123 form, completed by QPs to certify that the infant/toddler has completed all screenings, evaluations and/or assessments necessary to determine the need for the ICF/IID or ICF/ORC level of care established by the Department of Human Services (DHS) for enrollment in the Infants, Toddlers and Families Waiver.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The following process is used to evaluate infants and toddlers need for the ICF/IID or ICF/ORC level of care: a) the service coordinator identifies the infant or toddler as being likely to qualify for the ICF/IID or ICF/ORC level of care based on DHS criteria; b) the service coordinator explains level of care eligibility criteria to the family and obtains permission to submit evaluation, and/or assessment information to a QP for determination of level of care eligibility; c) the QP completes a determination on level of care (Form PW 123) by certifying that the infant/toddler has completed all necessary screenings, evaluations and/or assessments, including a physician completed medical necessity form that indicates an infant/toddler's need for early intervention services and forwards the eligibility form to the infant/toddler early intervention program; d) the infant/toddler early intervention program certifies the QP's waiver eligibility determination on Form PW 123, files the certification form in the child's record and authorizes the service coordinator to advise the family regarding the determination; e) the service coordinator advises the family regarding their child's level of care determination and requests that the family signify their choice to receive waiver-funded IFSP services by signing Form PW 457; f) when the family chooses waiver funding for IFSP services on Form PW 457, the infant/toddler early intervention program forwards the HCBS Eligibility/Ineligibility/Change Form (PA 1768) to the CAO; the CAO issues a notice of waiver eligibility to the family (PA/FS 162) and to the infant/toddler early intervention program, and; g) the infant/toddler early intervention program advises the service coordinator and provider(s) of the effective date of waiver eligibility for purposes of the IFSP.

Reevaluations for continued need for ICF/IID or ICF/ORC levels of care follow the same basic process: a) a QP evaluates to determine whether the infant or toddler continues to meet the ICF/IID or ICF/ORC level of care eligibility criteria, completes the first portion of the annual re-certification Form PW 123 A and forwards it to the infant/toddler early intervention program. The infant/toddler early intervention program certifies whether the infant or toddler continues to meet waiver eligibility requirements and files the completed Form 123A in the child's record.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Service coordinators ensure timely reevaluations of level of care as a component of their responsibilities to locate, coordinate and monitor services.

Re-certification of need for an ICF/IID or ICF/ORC level of care shall be made within 365 days of the infant or toddler's initial certification and each subsequent re-certification. The re-certification shall be completed by a QP and shall be based on the infant or toddler's continuing need for an ICF/IID or ICF/ORC level of care, his/her progress toward meeting plan objectives, the appropriateness of the plan of care, and consideration of alternate methods of care.

Additionally, infant/toddler early intervention programs have been delegated responsibility for ensuring timely re-evaluations of level of care pursuant to provisions established in OCDEL's Operating Agreement with infant/toddler early intervention programs.

The OCDEL monitors infant/toddler early intervention program performance related to timely reevaluations by reviewing data from the statewide data system, PELICAN-EI and through on-site reviews.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Statewide data system

Infant/toddler records maintained in infant/toddler Early Intervention programs.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of infants/toddlers who receive a level of care evaluation when the infant/toddler is determined likely to be eligible for an ICF/IID or ICF/ORC level of care. Numerator = the number of infants/toddlers with a level of care form (PW-123). Denominator = infants/toddlers with a fifty percent (50%) delay in one or thirty-three percent (33%) delay in two of the five developmental areas.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of infants/toddlers that are re-evaluated for continued eligibility for the waiver on an annual basis. Numerator = number of infant/toddlers with a re-certification of need form. Denominator = number of infant/toddlers with a certification of need form.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of infants and toddlers who are funded by the ITF Waiver that have level of care determination consistent with state policy. Numerator = number of infants and toddlers with a level of care form (PA-123). Denominator = number of infants and toddlers funded by the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Waiver assurance data for all waiver participants is able to be generated from the statewide data system at any time for monitoring. A series of data reports have been developed and are accessible for infant/toddler early intervention program's use to monitor their performance. OCDEL also generates data reports for a series of data indicators on an annual basis and provides the data reports to infant/toddler early intervention programs so that programs can validate their data. The state requires infant/toddler early intervention programs to enter missing data elements within prescribed time frames to address area(s) that are not at 100 percent compliance. OCDEL generates a subsequent report from the statewide data system to validate that correction has taken place.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Individual problem(s) related to level of care determinations or re-evaluations that are identified through the statewide data system review are documented in a statewide data report issued to infant/toddler early intervention programs. The infant/toddler early intervention programs address data issues in their Quality Enhancement Plan (QEP). Infant/Toddler programs are required to submit a QEP within 45 days of receipt of the finding report and OCDEL requires immediate correction of issues such as inappropriate level of care determinations and/or untimely re-evaluations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service coordinators explain feasible alternatives available under the waiver along with other feasible funding and program alternatives in the home and community to families of infants and toddlers eligible for the Infants, Toddlers and Families Wavier. Service coordinators offer the family the choice of receiving waiver-funded IFSP services, non-waiver services, or services in an ICF/IID or ICF/ORC.

Before the family is offered the choice of services, the service coordinator is responsible to assure that the family is informed 1) of other feasible funding alternatives for the child, such as Early Periodic Screening Diagnosis and Treatment (EPSDT), and county-funded early intervention, 2) that services authorized in the child's IFSP will not be affected by the family's choice to receive or not receive waiver-funded services, 3) that waiver-funded services can be authorized in conjunction with other services the child needs as part of the IFSP; 4) of other funding streams, such as federal Part C grant funds, state and county early intervention revenues and the Medical Assistance/Early Intervention (MA/EI) State-Established Fee Schedule; 5) that waiver-funded services must occur in natural environments with the participation of the family or caregiver; 6) and that the family can change their choice to receive or not receive waiver-funded services at any time.

The family's choice to receive waiver-funded services or services in an ICF/IID or ICF/ORC is documented on Form 457, Certification of Choice, Infants, Toddlers & Families Medicaid Waiver. The Notice of Opportunity for Fair Hearing for Medicaid Waiver for Infants, Toddlers and Families is Form PW 457A.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Child records are maintained in infant/toddler early intervention programs.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Commonwealth of Pennsylvania, in concurrence with the General Education Provisions Act (GEPA) ensures equitable access and participation in programs and services for eligible infants and toddlers through the availability of public awareness brochures, forms and information materials in English and Spanish languages. Other language translations are provided as requested.

The Early Intervention Services regulations at 55 Pa. Code § 4226.62 require that tests and other evaluation materials and procedures are administered in the parent's native language unless it is clearly not feasible to do so. In addition, assessment and evaluation procedures are administered so as not be racially or culturally discriminatory. Under 55 Pa. Code § 4226.92, Infant/toddler Early Intervention programs are required to fully inform parents of all information relevant to the activity for which consent is sought, in the parent's native language. In addition, Infant/toddler Early Intervention programs, shall take steps to ensure that prior notices are translated orally or by other means when the native language of the parent is not a written language. Bilingual service managers are provided when needed. Sign language is used with infants/toddlers and families who are deaf and hard of hearing, when requested. DHS offers the use of Language Service Associates for individuals who are not English speaking and interpreters are available for public meetings or hearings as needed.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Other Service	**Special Instruction**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Special Instruction

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Special instruction includes the following:

Designing the learning environment and activities that promote the acquisition of skills by an infant or toddler with a disability in a variety of developmental areas, including cognitive processes and social interaction; curriculum planning, including the planned interaction of personnel, materials and time and space, that leads to achieving the outcomes on the IFSP; providing the family with information, skills and support related to enhancing the skill development of the infant or toddler with a disability; working with the infant or toddler with a disability and family to enhance the infant or toddler's development.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Rehabilitation services and/or personal care services, as well as therapies covered under EPSDT, are not provided under the ITF Waiver. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Early Interventionist
Agency	Early Interventionist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Special Instruction

Provider Category:
Individual
Provider Type:

Early Interventionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An early interventionist shall have one of the following groups of minimum qualifications:

(1) A bachelor's degree from an accredited college or university in early intervention, early childhood education, child development, special education or family studies, and 1 year of full-time or full-time equivalent experience working directly with preschool children with disabilities and their families or a university-supervised or college supervised student practicum or teaching experience with preschool children with disabilities and their families.
(2) A bachelor's degree from an accredited college or university that includes 15 credit hours in early intervention, early childhood education, child development, special education or family studies, and 1 year of full-time or full-time equivalent experience working directly with preschool children with disabilities and their families or a college/university-supervised student practicum or teaching experience with preschool children with disabilities and their families; and demonstrated knowledge, understanding, and skills needed to perform the functions specified in 55 Pa. Code § 4226.54 (relating to early interventionist responsibilities).

Additionally shall have:
(1) Have a signed OCDEL provider agreement on file with OCDEL.
(2) Complete OCDEL required training.
(3) Have commercial general liability, professional liability (including malpractice) and worker's compensation insurance.
(4) Comply with the criminal history record information and child abuse clearance requirements specified in 23 Pa C.S. Chapter 63 (relating to Child Protective Services Law (CPSL)); 55 Pa. Code Chapter 3490 (relating to protective services); and 55 Pa. Code Chapter 4226 (relating to early intervention services).

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Infant/toddler early intervention programs

2. Office of Child Development and Early Learning

Frequency of Verification:

Prior to service provision and, at a mimumum, annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Special Instruction

Provider Category:

Agency

Provider Type:

Early Interventionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

(1) A bachelor's degree from an accredited college or university in early intervention, early childhood education, child development, special education or family studies, and 1 year of full-time or full-time equivalent experience working directly with preschool children with disabilities and their families or a university-supervised or college supervised student practicum or teaching experience with preschool children with disabilities and their families.
OR
(2) A bachelor's degree from an accredited college or university that includes 15 credit hours in early intervention, early childhood education, child development, special education or family studies, and 1 year of full-time or full-time equivalent experience working directly with preschool children with disabilities and their families or a college/university-supervised student practicum or teaching experience with preschool children with disabilities and their families; and demonstrated knowledge, understanding, and skills needed to perform the functions specified in 55 Pa. Code § 4226.54 (relating to early interventionist responsibilities).

Additionally shall have:
(1) Have a signed OCDEL provider agreement on file with OCDEL.
(2) Complete OCDEL required training.
(3) Have commercial general liability, professional liability (including malpractice) and worker's compensation insurance.
(4) Comply with the criminal history record information and child abuse clearance requirements specified in 23 Pa C.S. Chapter 63 (relating to Child Protective Services Law (CPSL)); 55 Pa. Code Chapter 3490 (relating to protective services); and 55 Pa. Code Chapter 4226 (relating to early intervention services).

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Infant/toddler early intervention programs

2. Office of Child Development and Early Learning

Frequency of Verification:

Prior to service provision and, at a minimum, annually thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Infant/toddler early intervention programs or contracted agencies provide service coordination and case management activities. Contracted entities are typically management agencies that infant/toddler early intervention programs have chosen to use to perform the case management functions of locating, coordinating and monitoring services for them. Infant/toddler early intervention programs use their own selection process in determining what agency to use for contracted service coordination activities. Service coordination qualifications and responsibilities are outlined in the 55 Pa. Code Chapter 4226 regulations. OCDEL retains the authority to provide the infant/toddler early intervention programs with direction that the infant/toddler early intervention programs must follow in the selection of entities to perform service coordination activities. Performance of service coordination and case management activities by a contracted agency is monitored by the infant/toddler early intervention programs on an annual basis. In addition, OCDEL monitors service coordination and case management activities during ongoing technical assistance activities and during the cyclical verification process of infant/toddler early intervention programs.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with Child Protective Services Law (CPSL) and Title 55 Public Welfare, Chapter 4226 Early Intervention Services Regulations, §4226.31, employees having direct contact with children must obtain the following three certifications:

-Report of criminal history from the Pennsylvania State Police (PSP);
-Child Abuse History Certification from the Department of Human Services (Child Abuse); and
-Fingerprint based federal criminal history submitted through the Pennsylvania State Police or its authorized agent (FBI).

All certifications are required to be obtained every 60 months.

The Operating Agreement between OCDEL and infant/toddler early intervention programs specifies that infant/toddler early intervention programs ensure that all waiver service providers and service coordinators have the required child abuse and criminal history certifications as part of the process for determining that providers and service coordinators meet qualifications as service providers. Infant/toddler early intervention programs' self verification includes an assurance statement that all providers met necessary qualifications, including certifications. Provider monitoring completed by infant/toddler early intervention programs on an annual basis, documents that all early intervention personnel and service coordinators have the required certifications.

OCDEL validates that providers and service coordinators have the required child abuse and criminal history certifications during verification of infant/toddler early intervention programs.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

In accordance with provisions of 23 Pa. C.S. Chapter 63 (relating to Child Protective Services Law (CPSL)) and regulations in Chapter 3490 (relating to protective services) a child abuse background certification is required for all employees who will have direct contact with children.

Childline, a unit within the Office of Children, Youth, and Families (OCYF) in the Department of Human Services performs functions related to obtaining child abuse certifications, dispensing the results to agencies, and maintaining the Statewide Central Abuse Register.

Pursuant to 55 PA Code Chapter 4226, Early Intervention Services, and the Operating Agreement between the OCDEL and infant/toddler early intervention programs, infant/toddler early intervention programs are responsible for ensuring that providers, including service coordinators meet provider qualifications, including child abuse and criminal history certifications.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

  Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

  [ ] **Self-directed**

  [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

- ( ) **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Pursuant to OCDEL's Operating Agreement with Infant/Toddler Early Intervention programs, providers cannot be limited in any way which violates the assurance of freedom of choice under the Medical Assistance Program or the waiver.

The Infant/Toddler Early Intervention Program must allow any qualified providers that sign a Provider Agreement for Participation in the Pennsylvania Medical Assistance Program for Early Intervention Services in the Infants, Toddlers and Families Medicaid Waiver to provide services if an infant's or toddler's family or their representative requests the service of such provider, the provider agrees to serve the infant or toddler and family, and the provider agrees to accept the rates established by the Department as payment in full for the service.

OCDEL has issued a policy related to the process for qualifying as a provider under the Infants, Toddlers and Families Waiver. This policy can be found on the Departments of Education and Human Services websites under Early Intervention.

In addition, OCDEL maintains a statewide list of current waiver providers that infant/toddler Early Intervention programs share with families during the planning process. Families are advised of their right to the provider of their choice as part of the notice for fair hearing contained in the Eligibility for Infants, Toddlers and Families Medicaid Waiver Announcement, EI-08 #10.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of non-licensed/non-certified providers who adhere to waiver requirements. Numerator = Number of non-licensed/ non-certified providers that have signed a provider agreement with OCDEL. Denominator = number of enrolled providers.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider agreements and enrolled providers

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of providers that meet State training requirements. Numerator = number of providers that meet training requirements. Denominator = number of enrolled providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Office of Medical Assistance Programs provides a third review of provider qualifications in their process of enrolling providers in the states Medicaid Management Information System.

Additionally, infant/toddler early intervention programs have responsibility for assuring that employees and contractors are screened to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care programs in accordance with Medical Assistance Bulletin, titled: Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Infant Toddler Early Intervention programs are responsible for annual monitoring reviews of each provider of waiver services to ensure the provider is abiding by all state and federal Early Intervention regulations and waiver requirements. The review shall include visits with infants and toddlers and families in the family home and community settings where services are provided, a review of program child records and a review of service coordination monitoring.

Infant/Toddler Early Intervention Programs must maintain documentation of the review of each provider, including the date the monitoring occurred, the names of the waiver participants monitored, the findings of the review, and the Quality Enhancement Plan (QEP) developed by the provider, which includes what will be done to remedy issues of noncompliance with the Provider Agreement, state and federal Early Intervention regulations, policy announcements, or waiver requirements and the timeframes for resolving each area of noncompliance.

OCDEL reviews the Infant/Toddler Early Intervention program's provider monitoring review during verification visits. Individual problem(s) identified through OCDEL's verification visits are documented in a findings report and addressed through the Infant/Toddler Early Intervention program's QEP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Participants in the ITF Waiver are infants and toddlers, age birth to the child's third birthday. Infants or toddlers live with their families and are not subject to provider-owned or controlled residential settings; the child's family assures that their home is accessible to the child.

Service settings are selected by the infant or toddler's family based on the infant or toddler's needs and the family's preferences. Services are provided in the child & family's home or in a community setting, such as a day care, park, store or restaurant. The service setting(s) are identified and documented in the Individualized Family Service Plan (IFSP), that is a child and family-centered service plan.

The state ascertains that all waiver settings meet federal HCB Setting requirements by establishing policy for services settings to be in the child's natural environment and by continuous review of the child and family's IFSP that includes service locations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individualized Family Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

As described in the State Plan Amendment for "Children Under Age Three With a Developmental Delay", the minimum case manager qualifications are:
1. A Bachelor's of Social Sciences (BSS) degree from an accredited college or university which includes 12 college credits in Early Intervention, early childhood special education, ear childhood education, child development, special education, family counseling, family studies, social welfare, psychology, or other comparable social sciences, and 3 years of full-time or full-time equivalent experience working with or providing counseling to children, families or individuals with developmental disabilities and documented case management training.
2. a Bachelors of Arts (BA) degree from an accredited college or university which includes 12 college credits in Earl Intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology, or other comparable social sciences, and 3 years of full-time or full-time equivalent experience working with or providing counseling to children, families or individuals with developmental disabilities and documented case management training.

Additionally, the Pennsylvania State Early Intervention regulations (§ 4226.53) describes the Case Manager as:

Service coordinator requirements and qualifications.
(c) A service coordinator shall have one of the following groups of minimum qualifications:

(1) A bachelor’s degree from an accredited college or university which includes 12 college credits in early intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology or other comparable social sciences, and 1 year of full-time or full-time-equivalent experience working with or providing counseling to children, families or individuals with disabilities.

(2) An associate’s degree, or 60 credit hours, from an accredited college or university in early intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology, or other comparable social sciences, and 3 years of full-time or full-time-equivalent experience working with or providing counseling to children, families or individuals with disabilities.

(3) Certification by the Pennsylvania Civil Service Commission as meeting the qualifications of a Caseworker 2 or 3 classification.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best

interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Service planning and delivery are founded on a partnership between families and their Early Intervention team that is focused on meeting the unique needs of the infant or toddler, addressing the concerns and priorities of each family and building on family and community resources.

The Early Intervention Services regulations at 55 Pa. Code§ 4226.61 establish standards for the multi-disciplinary evaluation (MDE) and family assessment, which includes a written report that must be completed and provided to the infant/toddler's family within 30 days of the MDE. The Individualized Family Service Plan (IFSP) is based on the MDE and assessment. Early Intervention Services regulations at 55 Pa. Code §§ 4226.72-4226.75 describe the procedures for IFSP development and review, participants in IFSP meetings and content and implementation of the IFSP. Other family members and/or advocates or persons outside the family can participate if the parents request.

The child and family's service coordinator serves as a single point of contact and provides service coordination activities as described in 55 Pa. Code § 4226.52 to support the family. Per the Eligibility for the Infants, Toddlers and Families Medicaid Waiver announcement, EI-08 #10, the service coordinator is responsible for explaining the waiver along with other feasible alternatives for funding Early Intervention services to families. The service coordinator also explains that infants and toddlers in the waiver maintain access to all services covered in the State Plan, including EPSDT services. The service coordinator assists the family to obtain needed supports, including identifying available service providers. Assistance in identifying available service providers is achieved by providing families with a statewide list of current waiver providers compiled by OCDEL and by advising families that a current list of providers is available on the Departments of Education and Human Services websites under Early Intervention.

Numerous publications, including but not limited to, A Family's Introduction to Early Intervention Services in Pennsylvania; Early Intervention Supports and Services - Facts for Families; guidelines to support the MDE/IFSP through annotated MDE and IFSP documents, family resources publications, guidelines for the transition process and Problem Solving in EI brochure are made available to families to support them to direct and be actively engaged in the IFSP process. These materials can be accessed by searching in the "Families" page of http://www.eita-pa.org.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

In accordance with 55 PA Code Chapter 4226, Early Intervention Services, an initial and annual multi-disciplinary evaluation (MDE) is conducted for each infant or toddler with a disability. Families, with the assistance of the service coordinator determine the composition of the MDE team. The MDE is based on a review of the pertinent records related to the child's current health status and medical history and an evaluation of the childs level of functioning in each of five developmental areas: cognitive development; physical development, including vision and hearing; communication development; social and emotional development; and adaptive development. The MDE includes an assessment of the unique needs of the child in terms of each of the aforementioned developmental areas, including the identification of services appropriate to meet those needs. Also included in the MDE is a voluntary and family directed, family assessment that is designed to determine the resources, priorities and concerns of the family and to identify the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

Following the MDE the child's Individualized Family Service Plan (IFSP) is developed by an appropriately constituted team. The team includes the infant or toddler's service coordinator, who has responsibility for facilitating the development of the IFSP; the parent of the infant or toddler; other family members and/or an advocate person outside the family, if requested by the parent; a person directly involved in conducting the evaluations and assessments (relating to the MDE); and persons who will be providing services to the infant or toddler, as appropriate. The plan is developed within 45 days of the date of the referral to early intervention and on an annual basis thereafter.

The IFSP must be in writing, in the standardized format prescribed by the state and must include:

(1) A statement of the present levels in each of the five aforementioned developmental areas.

(2) With the concurrence of the family, a statement of the family's resources, priorities and concerns related to enhancing the development of the infant or toddler.

(3) A statement of the major outcomes expected to be achieved for the infant or toddler and their family, and the criteria, procedures and timelines used to determine:

A. The degree to which progress toward achieving the outcomes is being made.

B. Whether modification or revision of the outcomes or services is necessary.

(4) A statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler and the family to achieve the outcomes required in (3), including:

A. The frequency and intensity of the services. Frequency and intensity are the number of days or sessions that a service will be provided and the length of time the service is provided during each session.

B. The natural environments in which early intervention services will be provided.

C. The payment arrangements, if any

D. The unit cost for each service.

(5) A statement of medical and other services that the infant or toddler needs and the funding sources to be used to pay for those services, or the steps that will be taken to secure those services through public or private sources.

(6) The projected dates for initiation of early intervention services and the duration of the services.

(7) The identity of the service coordinator that will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

(8) A statement of the steps to be taken to support the transition of the toddler to preschool services under Part B of IDEA or other appropriate services.

IFSP meetings are held in settings and at times that are convenient to the family; in the native language of the parent, unless it is clearly not feasible to do so, and in a manner that ensures that the early intervention services to be provided to an infant or toddler with a disability are selected in collaboration with the parent.

A review of the IFSP shall be conducted every 6 months or more frequently if conditions warrant or if the family requests such a review. The purpose of the review is to determine: 1) the degree to which progress toward achieving the outcomes is being made and, 2) whether modification or revision of the outcomes or services is necessary.

The infant/toddler early intervention program, through the service coordinator, is responsible to explain waiver funding for IFSP services to families only after the child's services in the IFSP are identified and it is determined that the child is likely to meet the level of care criteria for the waiver. The explanation includes a description of the nature and type of services being offered under the waiver, including the option of choosing waiver funded services with or without services funded by alternative sources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Due to the service delivery model of services being provided to infants and toddlers in the home with the family or caregiver present and participating in service delivery there is minimal to no risk to the infant or toddler. However, the MDE and family directed assessment described in Appendix D-1:3(d) assists in identifying any potential risks or infant or toddler needs. Service coordinators discuss any identified risks with the family and IFSP team. With family concurrence, any identified risks along with necessary strategies for mitigating risk(s) are incorporated into the IFSP.

55 PA Code Chapter § 4226.75, requires that to the maximum extent appropriate services should be provided in the infant or toddler's natural environment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

In order to facilitate a family’s choice of a provider, the service coordinator supporting the family informs the family that they have the option to choose provider(s) from the statewide provider list at the initial individualized family service plan (IFSP) team meeting and whenever an IFSP team has determined that an infant or toddler requires an additional service. Service coordinators also provide the family with information related to the providers’ qualifications as well as location and availability of providers. The service coordinator informs the family that if the family does not indicate a choice of provider, a provider will be assigned to the child and family.

The statewide list of current waiver providers, compiled by the OCDEL, is posted on the Departments of Education and Human Services websites. The OCDEL also provides information to potential providers regarding the process for qualifying as an Infants, Toddlers and Families Waiver provider on its websites.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

As described in D-1 (d), the plan (IFSP) utilized is standardized format prescribed by the state. The IFSP is a module of the statewide case management data system; it has been designed in a manner that prevents approval of an IFSP that is missing critical components.

In addition, the OCDEL reviews IFSPs during the on-site review of each infant/toddler early intervention program described in Appendix A:3. The Verification Tool used to conduct these verification reviews includes indicators, including but not limited to, whether the IFSP 1) is developed in accordance with waiver policies and procedures; 2) meets the needs of the infant or toddler; and 3) is updated and revised as necessary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Service coordination is an active and ongoing process that includes the responsibility for monitoring the implementation of the IFSP and the infant's/toddler's health and welfare through periodic monitoring oversight. 55 Pa. Code § 4226.72 establishes procedures for IFSP development, review and evaluation. This regulation requires that the IFSP be reviewed every 6 months, or more frequently if conditions warrant, or if the family requests such a review. An IFSP meeting is required to be held at least annually and, as appropriate, to revise the plan. The IFSP review assists the child's team in determining: 1) whether services were provided in accordance with the IFSP; 2) the degree to which progress toward achieving the outcomes is being made and whether modification or revision of the outcomes or supports and services is necessary; 3) any potential changes or newly identified need(s) for the child with the family; and 4) that the child's health and welfare are assured.

Infant/Toddler Early Intervention program oversight of service coordinator monitoring, plan development and implementation along with procedural safeguards for fair hearing and additional dispute resolution processes assure prompt follow up of identified problems, including problems identified by families, service providers and others. Information gathered from monitoring is included in service coordination notes and child progress notes. This information is reviewed by OCDEL during verification reviews of each Infant/Toddler Early Intervention program, and on an as needed basis. Service coordinator activities are monitored on an ongoing basis by early intervention coordinators or service coordinator supervisors through the early intervention coordinator or service coordinator supervisor's review of the IFSP, service coordinator notes, etc., with any identified issues being addressed through the supervisory process. In addition, Infant/Toddler Early Intervention programs are required to annually review service coordination activities through use of a state developed service coordination monitoring tool that mirrors the verification tool utilized by OCDEL to monitor Infant/Toddler Early Intervention programs. The service coordination monitoring tool includes a scoring mechanism.; Infant/Toddler Early Intervention programs are required to address any identified issues and document correction of any issues in an improvement plan. Review of the Infant/Toddler Early Intervention program's service coordination monitoring occurs during OCDEL's verification process. Service coordination activities, such as timely plan development, are monitored through review of the statewide data system, PELICAN-EI; identified issues are addressed through the statewide data system review process described throughout this application.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of IFSPs that address infants/toddler's assessed needs. Numerator = all infants/toddlers enrolled in the waiver with an IFSP. Denominator = all infants/toddlers enrolled in the waiver.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of plans for infants/toddlers enrolled in the waiver that were developed within 45 days of referral to early intervention. Numerator = number of plans for infants/toddlers enrolled in the waiver that were developed within 45 days of referral. Denominator = number of infants/toddlers active with plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of plans for infants/toddlers enrolled in the waiver that are updated annually. Numerator = number of plans that are updated annually. Denominator = number of initial plans eligible for an annual update.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,***

amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of plans implemented as defined in the IFSP. Numerator = number of plans with services delivered within 14 days of development of the plan. Denominator = number of plans implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of families who are afforded choice between waiver providers. Numerator = number of families of infants/toddlers enrolled in the waiver that were afforded choice of provider. Denominator = number of infants/toddlers enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of families of infants/toddlers enrolled in the waiver that are afforded choice between waiver services and institutional care. Numerator = number of families that are afforded choice between waiver services and institutional care. Denominator = number of infants/toddlers enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Statewide Data System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The ongoing review of statewide data, as described in Appendix A, ensures that data related to the waiver program is proactively reviewed according to scheduled timelines. In addition, waiver assurance data reports can be generated from the statewide data system at any time for monitoring by both the state and local Early Intervention programs.

In addition to reports on compliance data, key data quality components have been identified by BEISFS and reports are available to monitor data quality. Reports on data quality include the identification of invalid data entries and missing data elements, including documentation of waiver procedures such as level of care determinations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

Individual problem(s) are identified through two methods: 1) the findings report from the verification process; and 2) data analysis through the annual determination process. Following the identification of an individual concern, local Early Intervention programs develop Quality Enhancement Plans (QEPs) which include the activities needed to address identified concerns and the timelines for correction. BEISFS advisors approve all QEP activities and timelines. The BEISFS advisor is responsible for validating that all areas of individual concerns are corrected as soon as possible, within one year at the latest. Additional contacts from BEISFS staff may occur at the discretion of BEISFS if there is a significant decrease in program performance and individual concerns arise.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As part of the eligibility determination for the waiver and in accordance with the Eligibility for the Infants, Toddlers and Families Medicaid Waiver Announcement, EI-08 #10, service coordinators inform families of infants and toddlers of their right to fair hearing before the Department of Human Services (DHS), Bureau of Hearings and Appeals. The family has a right to a fair hearing when the following occurs: 1) the family has not been given information about the waiver, including information on how to enroll; 2) the family has not been given the choice to have a determination of their child's level of care; 3) the family has not been given the choice to receive waiver-funded services or services in an ICF/IID or ICF/ORC; 4) the family has been denied waiver-funded service(s) of their choice for their child; 5) the family has been denied a waiver-funded provider of their choice for their child; or 6) the family disagrees with a decision to deny, suspend, reduce or terminate services that are funded under the waiver. The family's appeal rights and instructions for filing an appeal are contained in Form No. 457-A. A copy of the form and instructions are included in the aforementioned eligibility announcement. The Infant/Toddler Early Intervention program is responsible to provide the family with a copy of Form No. 457-A, and to retain a copy of appeals for a minimum of three years. Families are provided with a verbal explanation of the family's right to fair hearing and appeal, including their right for service(s) to continue during the period the child/family's appeal is under consideration, provided the appeal is filed within the indicated time frames for filling an appeal, along with a written copy of Form No. 457-A at the time of enrollment and at any other time that it is requested. The Infant/Toddler Early Intervention program is responsible to participate in any fair hearing regarding the ITF Waiver. The service coordinator or other Infant/Toddler Early Intervention program designee, on request of the family, will assist the family in filing for fair hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Pursuant to 55 Pa. Code § 4226.91, Infant/Toddler Early Intervention programs are responsible for adopting procedural safeguards that meet the requirements of Chapter 4226. These procedural safeguards include: 1) conflict resolution; 2) mediation; 3) due process procedures; and 4) parental rights in due process hearings. A parent may choose any, some or all of the above options to raise a complaint. The choice of one dispute resolution process option does not preclude the parent from choosing any other option nor does the parent have to exhaust any one option in order to utilize another.

In accordance with 55 Pa. Code § 4226.98, parents of infants and toddlers have the right to mediation as a means to resolve complaints related to identification, evaluation or placement of the infant or toddler, or the provision of appropriate early intervention services. Mediation is offered to parents who request a due process hearing however, mediation may not be used to deny or delay a parent's right to a due process hearing. Mediation sessions are conducted by qualified and impartial mediators through the State Office for Dispute Resolution (ODR). The mediation session must be scheduled within 10 calendar days of the request for mediation or a due process hearing and shall be held in a location that is convenient to the parties of the dispute. An agreement reached by the parties to the dispute in the mediation session must be documented in a written mediation agreement.

Pursuant to 55 Pa. Code § 4226.98 Infant/Toddler Early Intervention programs are required to establish procedures to explain the benefits of the mediation process and to encourage its use, whereby a parent who chooses not to use the mediation process may request a meeting, at a time and location convenient to the parent, with a disinterested party or a parent training and information center or community parent resource center or an alternative dispute resolution entity.

In accordance with 55 Pa. Code § 4226.97, Infant/Toddler Early Intervention programs are required to establish a system of conflict resolution whereby parents, providers, as appropriate, or other parties may request a meeting with the county administrative staff to discuss and resolve issues relating to the provision of early intervention services.

In accordance with 55 Pa. Code § 4226.99, infant and toddler early intervention programs are required to implement procedures to ensure that the resolution of requests for due process hearings by parents concerning any of the matters relating to prior notice on behalf of an individual child is not delayed. If preservation of waiver service eligibility and funding is at issue, DHS fair hearing procedures contained in the announcement referenced in F-1 should be pursued.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Office of Child Development and Early Learning (OCDEL)

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pennsylvania has established procedures in Announcement EI-11 #01, titled, IDEA Early Intervention Complaint Procedures, for filing, investigating and resolving complaints within the Infant/Toddler Early Intervention system related to any alleged violation of requirements of Part C of the Individuals with Disabilities Education Act (IDEA), Pennsylvania Act 212-1990 and other applicable state and federal legislation or regulations. In accordance with this policy, complaints are filed with OCDEL for timely resolution of the complaint; OCDEL has 60 days to complete a complaint investigation and issue a report requesting that Infant/Toddler Early Intervention programs take any necessary appropriate action.

Complaint procedures include, but are not limited to, interviews with the complainant, agency personnel, and/or Infant/Toddler Early Intervention programs; review of records; contact with parents; and meetings, as necessary, with involved parties. Substantiated complaints result in corrective actions within 30 days of the completion of the complaint investigation. Corrective actions are monitored by OCDEL. If full implementation of the corrective action plan requires more than 30 calendar days, the respective early intervention program will develop a corrective action plan with time frames as directed and approved by OCDEL.

State early intervention regulations require that all early intervention staff are trained on procedural safeguards on an annual basis. OCDEL ensures that parents receive information about their rights through training, education, dissemination of materials about procedural safeguards, and through verification of Infant/Toddler Early Intervention programs.

A database that identifies each complaint is maintained. OCDEL compiles periodic statistical reports that are shared with Infant/Toddler Early Intervention programs, state and local interagency coordinating councils and others.
Families of infants or toddlers enrolled in the Infants, Toddlers and Families Waiver who elect to make a complaint through this complaint process are informed that doing so is not a pre-requisite or substitute for a fair hearing under the waiver.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All providers within the early intervention system are mandated reporters. Mandated reporters must report suspected child abuse, including neglect and exploitation to ChildLine, Pennsylvania's Statewide Child Abuse Hotline at: 1-800-932-0313 or through the child welfare portal at: http://www.keepkidssafe.pa.gov. The children and youth agency is responsible for investigating reports of suspected abuse.

OCDEL requires that in addition to suspected child abuse being reported to Childline, a person who provides early intervention services to infants or toddlers observes or otherwise is made aware that a provider of early intervention services committed an act of suspected child abuse must also notify the infant/toddler early intervention program that has responsibility for providing services to the infant or toddler within 24 hours of observing or becoming aware of the suspected child abuse. A standardized Early Intervention Reportable Incident Form is used to notify infant/toddler early intervention programs of suspected child abuse. The infant/toddler early intervention program shall in turn submit the report to OCDEL within 48 hours of receipt of the incident report.

The infant/toddler early intervention program is responsible for initiating a review of the reported incident. The infant/toddler early intervention program review must be conducted in a manner that does not interfere with the county children and youth agency’s investigation.

The infant/toddler early intervention program's review process must be concluded and forwarded to OCDEL within 5 business days of the date that the children and youth agency issued its finding. The infant/toddler program is responsible for responding to OCDEL within 5 business days regarding any questions about the content of the report.

EI provider agencies and infant/toddler early intervention programs are required to have policies and procedures in place that ensure the safety of infant and toddlers receiving EI services during the children and youth agency's investigation and the infant/toddler early intervention program's review process. These policies and procedures must include disciplinary action or removal of a service provider when needed to ensure the safety of infants and toddlers receiving early intervention services.

OCDEL's incident management policy may be found on the Departments of Education and Human Services websites under early intervention.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Service Coordinators provide families with information concerning protections from abuse, neglect and exploitation at the time of intake and on an annual basis, thereafter. Service coordinators educate families about the content of the Department's website: www.KeepKidsSafe.pa.gov. This website is designed to serve as the hub for information related to critical components impacting child protection and includes an internet link and a toll free number for reporting child abuse. The service coordinator also advises families to contact the service coordinator or their supervisor for support if they have concerns that the early intervention provider has abused their child or has acted inappropriately.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Provider agencies are responsible for reviewing reportable incidents alleged to involve staff employed or under contract with the provider agency. Infant/toddler early intervention programs are responsible for reviewing reportable incidents alleged to involve independent providers that are not affiliated with an agency. The infant/toddler program is also responsible for reviewing the provider's report and approving the report or requesting additional information within five business days of receipt of the provider's report. If the infant/toddler program has any additional concerns about the EI provider's report, they shall also contact OCDEL. The review process shall be initiated by the EI provider and/or infant/toddler program within 24 hours of the submission of the EI reportable incident form. The review process shall be concluded within five business days of the date that the children and youth agency issued its finding.

OCDEL will review the EI provider and/or infant/toddler program's report and notify the infant/toddler program in writing within five business days of OCDEL's approval. If OCDEL determines that additional information is needed, a request for additional information will be forwarded to the infant/toddler program within 5 business days of receipt of the report. If additional information is satisfactory, OCDEL will notify the infant/toddler program within 5 business days of the approval of the additional information. It is the infant/toddler program's responsibility to notify the provider agency, as applicable.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OCDEL oversees the reporting of, and response to, incidents for infants and toddlers by reviewing incidents as they are submitted and, through on-site verification of infant/toddler early intervention programs to ensure that incidents are managed in accordance with the reportable incidents announcement.

OCDEL will compile and analyze the data on an annual basis to assure that any relevant information is used to prevent re-occurrence.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The OCDEL is the responsible state agency for oversight and the detecting of unauthorized use of restraints or seclusion. The following methods are used to detect the unauthorized use of restraint or seclusion:

1. Waiver services are provided in the infant/toddler's home or community setting with the presence and participation of the family/caregivers; therefore the family/caregiver is the first line of detection of the unauthorized use of restraint or seclusion.

2. OCDEL has issued policy in early intervention announcement 13-#07, titled: Positive Behavior Support that requires use of positive and prevention approaches in response to challenging behaviors and requires early intervention programs to have positive behavior support policies in place.

3. OCDEL has established policy in Announcement EI-21-01, titled: Reportable Incidents for Mandated Reporters. The use of restraint is reported as abuse and therefore, infant/toddler early intervention programs and OCDEL utilize this mechanism on an incident occurrence basis to detect the unauthorized use of restraint or seclusion.

4. Service coordinators have ongoing responsibility for monitoring services for infants/ toddlers and are required to meet with infants/toddlers and families at least once per every ninety days. Information related to service provision and child progress is collected during these visits that are often held during a service delivery visit therefore, the service coordinator is also used in the oversight of the unauthorized use of restraint or seclusion.

5. OCDEL conducts on-site verifications of infant/toddler early intervention programs. The standardized tool utilized during the on-site reviews gathers information including, but not limited to, service provision and reporting of incidents. The on-site review process serves as a mechanism for detecting the unauthorized use of restraints.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

OCDEL is the State agency responsible for detecting the unauthorized use of restrictive interventions. The following mechanisms are used to detect the unauthorized use of restrictive interventions:
1. Waiver services are provided in the infant/toddler's home or in a community setting with the presence and participation of the family/caregiver; thus, the family/caregiver is the first line of defense for detecting the unauthorized use of restrictive interventions.

2. Service coordinators have an ongoing responsibility for monitoring service delivery and are required to meet with infants/toddlers and families when conditions warrant and at least once every 6 months or if the family requests a meeting. Information related to service provision and child progress is collected during these meetings that are often held during service delivery; therefore, service coordinators also participate in the oversight of the detection of the unauthorized use of restrictive interventions.

3. OCDEL requires Infant/Toddler Early Intervention programs to have positive behavior support policies in place. Annual verification of Infant/Toddler Early Intervention programs includes a review that these policies have been developed.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

OCDEL is the State agency responsible for detecting the unauthorized use of seclusion. The following mechanisms are used to detect the unauthorized use of seclusion:
1. Waiver services are provided in the infant's/toddler's home or in a community setting with the presence and participation of the family/caregiver; thus, the family/caregiver is the first line of defense for detecting the unauthorized use of seclusion.

2. Service coordinators have ongoing responsibility for monitoring service delivery and are required to meet with infants/toddlers and families when conditions warrant and at least once every 6 months or if the family requests a meeting. Information related to service provision and child progress is collected during these meetings that are often held during service delivery; therefore, service coordinators also participate in the oversight of the detection of the unauthorized use of seclusion.

3. OCDEL requires Infant/Toddler Early Intervention programs to have positive behavior support policies in place. Annual verification of Infant/Toddler Early Intervention programs includes a review that these policies have been developed.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*
○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of providers that obtained necessary child abuse and criminal history clearances . Numerator = count of contracted providers that obtained necessary clearances. Denominator = all contracted providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of documented instances of abuse, neglect and exploitation that are managed in accordance with Department policy. Numerator = instances of abuse, neglect and exploitation that are managed in accordance with Department policy. Denominator = all documented instances of abuse.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of infant/toddler early intervention programs that develop positive behavior support and incident management policies in accordance with state established policies. Numerator = number of infant/toddler early intervention programs that develop positive behavior support and incident management policies. Denominator = number of infant/toddler early intervention programs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
policies and procedures

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of evaluations for infants and toddlers enrolled in the waiver that include health, vision and hearing summary information. Numerator = Number of evaluations for infants and toddlers enrolled in the waiver that include health, vision and hearing summary information. Denominator = all infant and toddler evaluations for infants and toddlers enrolled in the waiver.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Individual issues identified during the review of incidents would be addressed through the review process on a case by case basis.

Individual issues identified during the verification of infant/toddler early intervention programs is documented in a findings report and addressed through the QEP process.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

In Pennsylvania, the discovery and remediation process occurs throughout the year and is based on activities that occur at both the local and state level.

At the local level, BEISFS advisors, through their roles as primary contact with each Early Intervention program, participate in ongoing meetings that are designed to identify concerns, based on evidence, with the waiver assurances and to develop program improvement strategies. The Early Intervention programs' Quality Enhancement Plan (QEP) documents the implementation of improvement strategies.

The local Early Intervention programs' concerns and improvement strategies are reviewed at monthly BEISFS staff meetings in conjunction with information from the statewide data system. Data related to each waiver assurance is analyzed on both a monthly and annual basis to determine if non-compliance areas meet the threshold of a system-wide trend or pattern. The BEISFS staff meetings serve as BEIFS's continuous quality improvement (CQI) meetings and participants in the meetings include BEISFS Early Intervention Advisors, Division Chiefs and the Bureau Director. CQI team members have expertise in conducting monitoring of Early Intervention programs as well as the design and management of PELICAN-EI.

Any system-wide trends or patterns are analyzed. This analysis includes discussion related to root-cause analysis, brainstorming of CQI improvement strategies, and consideration of the impact of the proposed improvement strategies on the Early Intervention waiver services provided to infants, toddlers and their families. The process for analysis of trends or patterns is initiated with BEISFS and the discussion is shared with infant/toddler Early Intervention program leaders and other stakeholders during regularly scheduled meetings.

Implementation of CQI improvements may be made through standardization of processes, practices or forms; development of additional or revised reporting processes; or training or technical assistance for infant/toddler Early Intervention programs.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The process for monitoring and analyzing the effectiveness of system design changes mirrors the process that OCDEL utilizes for the analysis of information obtained through the discovery and remediation process.

On a monthly basis, BEISFS Early Intervention Advisors, Division Chiefs and the Bureau Director meet to analyze CQI improvement efforts. Data system reports are generated and reviewed to determine the effectiveness of CQI implementation. If CQI data reports do not show evidence of system improvement, modifications to system design changes are made as warranted. Reports are shared with stakeholders during regularly scheduled State Interagency Coordinating Council and Early Intervention program leadership meetings. System design changes may include modification to data elements or data collection procedures.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

BEISFS staff evaluates CQI improvement strategies, as appropriate, through the monthly discussion of topics including but not limited to, assessment/refinement of data for reliability and validity; opportunities for improvement of data collection; development of performance measures; trends or patterns demonstrated by the data; positive practices; and setting priorities and targets for improvement.

Stakeholder input on CQI improvement strategies is gathered from the State Interagency Coordinating Council, infant/toddler Early Intervention program leaders, providers of Early Intervention services, families whose children are enrolled in the Early Intervention program, and other constituent groups through regular meetings and workgroups held at a minimum of six times per calendar year.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**

- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The method employed to assure the integrity of payments made for the Infants, Toddlers and Families (ITF) Waiver services is to conduct an annual fiscal year audit of state government, county governments, and non-profit organizations in compliance with the requirements of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) contained at 2 CFR Part 200, Subpart F (replacing OMB Circular A-133). Title 45, CFR 75.501(i) incorporates the thresholds and deadlines of 2 CFR Part 200 as amended, and provides for-profit organizations with two options regarding the type of audit that will satisfy the audit requirements: 1) A financial audit conducted in accordance with generally accepted Government Auditing Standards (The Yellow Book), revised; or 2) An audit that meets the requirements contained in 2 CFR Part 200. An annual Single Audit is conducted on the Commonwealth of Pennsylvania jointly by the Pennsylvania Department of the Auditor General (an independent State government audit organization) and an independent certified public accounting (CPA) firm. The Office of Management and Budget (OMB) Compliance Supplement sets forth standards for obtaining consistency and uniformity for the audit of states, local governments, and non-profit organizations expending Federal awards. Additionally, the Compliance Supplement is based on the requirements of the Single Audit Act Amendments of 1996 and revision to OMB Circular A-133/2 CFR part 200, Subpart F, which provide for the issuance of a compliance supplement to assist auditors in performing the required audits. The guidelines presented in the Compliance Supplement are the basis for the financial and compliance testing of ITF Waiver payments. Sub-recipients of Federal awards, such as local county governments, are audited annually in accordance with the Uniform Guidance. County government audits are conducted by contracting with independent CPA firms or by independently elected county controllers (i.e. independent local government audit organizations). The Department of Human Services (DHS) releases an annual Single Audit Supplement (Supplement) publication to county governments and CPA firms which provides compliance requirements specific to DHS programs, including the ITF waiver, at the local government level. Payments made for waiver services are tested in accordance with the compliance requirements contained in the Supplement.

The purpose of the Supplement is to fill four basic needs: 1) a reference manual detailing additional financial and compliance requirements pertaining to specific DHS programs operated by local governments and/or private agencies; 2) an audit requirement to be referenced when contracting for Single Audit services, providing the auditing entity with the assurance that the final report package will be acceptable to DHS; 3) a vehicle for passing compliance requirements to a lower tier agency; and 4) additional guidance to be used in conjunction with the Uniform Guidance, Single Audit Act Amendments of 1996, Government Auditing Standards (commonly known as The Yellow Book) issued by the Comptroller General of the United States, OMB's Federal Compliance Supplement, and audit and accounting guidance issued by the American Institute of Certified Public Accountants (AICPA).

Claims for the provision of ITF waiver services flow directly from providers to the State's Medicaid Management Information System (MMIS). The MMIS interacts with PELICAN-EI, the statewide case management system, to confirm that the child is eligible for waiver services on the date of service, that the services were authorized on the child's IFSP, and that the claim does not exceed the number of authorized units of service and rate for the service. The MMIS is designed with unique procedure codes specific to Early Intervention services; claims that are submitted with incorrect codes are denied. Re-submission of the claim with the correct code is necessary for the claim to be paid. Additionally, duplicated claims are denied. The MMIS also controls the allowed units and rate for the claim. Claims that exceed the authorized total units or the statewide rate will be adjusted or denied. The Bureau of Data and Claims Management (BDCM) completes the following protocol as part of all claims processed in the State's MMIS:
• Monthly reviews are conducted to determine the timeliness of claims processing, such as assignment of an internal control number (ICN) to claims within 24 hours, paper claim retention requirements are being met, and all claims are adjudicated within defined timeframes.
• Quarterly reviews are also conducted to determine the quality of claims processing which includes reviewing a sample of claims to verify the accuracy and effectiveness of established claims resolution procedures and the quality of information manually entered from paper claims. Clean claim records are defined as claims or adjustments that can be processed without obtaining additional information from the provider of services or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim review for medical necessity. Claims processing requirements: - Adjudicate 90 percent of clean claim records within twelve (12) calendar days of the date of receipt of the claim. - Adjudicate 99 percent of all clean claims within seventy-one (71) calendar days of the date of receipt of the claim. - Adjudicate all claims (100 percent) within three hundred forty-five (345) calendar days of receipt of the claim, except those exempted by the Commonwealth.

In addition, infant/toddler Early Intervention programs, through service coordinators, review service notes submitted by providers that are signed by the provider and family as a mechanism to assure that services are being provided in accordance with the frequency and duration noted in the IFSP. The Office of Child Development and Early Learning (OCDEL) also reviews service notes submitted by providers during verification reviews as a mechanism to assure that services are being provided in accordance with the frequency and duration noted in the IFSP. OCDEL reviews data in the

statewide data system, PELICAN-EI, related to ITF waiver service provision and payment for ITF waiver services on a regular basis. Infant/toddler Early Intervention programs participate in the Medicaid Administrative Claiming (MAC) Random Moment Time Study (RMTS) as approved by CMS. Annual audits of infant/toddler Early Intervention programs are in accordance with the Uniform Guidance. Additional payment and fiscal safeguards are contained in the OCDEL's Operating Agreement with the infant/toddler Early Intervention programs. The infant/toddler Early Intervention programs and providers of services are responsible for maintaining records related to reporting and child records for eligible services for four years after services are furnished. The infant/toddler Early Intervention programs and providers of services are also required to retain records related to audits, litigation, or the settlement of claims until such audits, litigation, or claims have reached final disposition.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Office of Child Development and Early Learning (OCDEL) monitors and addresses improperly coded/paid claims through use of the statewide data system (PELICAN-EI). The numerator = the number of infant/toddler early intervention programs with accurately paid claims. The denominator = the number of infant/toddler early intervention programs with paid claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Office of Child Development and Early Learning (OCDEL) monitors contracted service rates through use of the statewide data system (PELICAN-EI). The numerator = the number of infant/toddler early intervention providers with contracts for waiver services using approved state rate. The denominator = the number of infant/toddler early intervention providers with contracts for waiver services.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Statewide Data System; service contract records

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Rate tables containing the state approved rates are stored in the state's MMIS. These rate tables are referenced for claims auditing and will reduce potential over payments by cutting back claims to the approved rate.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Individual problem(s) related to improperly coded or paid claims identified through the Statewide data system review and/or by other means are addressed with the billing provider in collaboration with the Bureau of Program Integrity. Claims errors shall be reported by the provider to the Bureau of Program Integrity in the form of a self-disclosure/audit that will be reviewed and acted upon as determined by the reviewer. Self-audit protocol details are found on the Department's website: Medical Assistance Provider Self Audit Protocol (pa.gov).

The MMIS is designed to deny claims that are submitted with incorrect codes; re-submission of the claim with the correct code is necessary for the claim to be paid. In addition, infant/toddler Early Intervention programs, through service coordinators, review service notes submitted by providers that are signed by the provider and family as a mechanism to assure that services are being provided in accordance with the frequency and duration noted in the IFSP. The OCDEL also reviews service notes submitted by providers during verification reviews as a mechanism to assure that services are being provided in accordance with the frequency and duration noted in the IFSP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment*

rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The OCDEL established maximum payment rates for the provider type providing special instruction under the waiver through a random time study completed in 1994. The random time study identified the real costs associated with service provision and allowed significant opportunity for public comment. Cost of living increases were applied periodically as a result of appropriations from the State legislature to increase the rates.

In 2005, in response to concerns about inconsistencies between the rates negotiated by the infant/toddler Early Intervention programs, the Department formed an Early Intervention rate study work group that included broad stakeholder representation to gather input.

As described in the ITF Waiver renewal application submitted in 2011, the OCDEL established state set rates for Early Intervention services, including ITF Waiver funded services, effective January 1, 2011. The maximum allowable amount previously used for rate negotiation was used as the state set rate in 2011. Payment rates are made available to waiver participants and the general public through OCDEL Announcements.

Since the state set rates have not changed since 2011 and there were statewide concerns with retaining qualified providers, the Governor's enacted budget included a rate increase starting in fiscal year 2019-2020. OCDEL issued Announcement EI-19 #01, 2019/2020 Rate Increase Distribution Plan for Infant Toddler - Early Intervention on July 8, 2019. This announcement included a 3% rate increase.

The OCDEL solicits public comment on rate determination methods through input obtained from the State Interagency Coordinating Council, infant/toddler Early Intervention programs and other constituent groups, such as provider associations, through regularly scheduled meetings. This input would be used if OCDEL considered changing the methodology for rate determination in the future.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims for the provision of waiver services flow directly from providers to the State's MMIS. The MMIS interacts with PELICAN-EI, the statewide system, to confirm that the child is eligible for waiver services on the date of service, that the services were authorized on the child's IFSP and that the claim does not exceed the number of authorized units of service and rate for the service.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with

42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The MMIS interacts with PELICAN-EI, the statewide case management system, to confirm that the infant/toddler is eligible for waiver services on the date of service, that the services were authorized on the child's IFSP and that the claim does not exceed the number of authorized units of service and rate for the service.

Infant/toddler Early Intervention program service coordinators review provider session notes that include a method that verifies that the service being billed was provided per 42 CFR § 455.20. Early Intervention coordinators also validate data in PELICAN-EI to assure that waiver services have been provided in accordance with the frequency and duration indicated in the infant/toddler's IFSP.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*2537.00*	*18454.00*	*20991.00*	*219192.00*	*6795.00*	*225987.00*	*204996.00*
2	*2537.00*	*18454.00*	*20991.00*	*219192.00*	*6795.00*	*225987.00*	*204996.00*
3	*2537.00*	*18454.00*	*20991.00*	*219192.00*	*6795.00*	*225987.00*	*204996.00*
4	*2537.00*	*18454.00*	*20991.00*	*219192.00*	*6795.00*	*225987.00*	*204996.00*
5	*2537.00*	*18454.00*	*20991.00*	*219192.00*	*6795.00*	*225987.00*	*204996.00*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*5300*	*5300*
Year 2	*5600*	*5600*

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 3	*5900*	*5900*
Year 4	*6200*	*6200*
Year 5	*6500*	*6500*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay is 205 days; this number is based on the Fiscal Year 18-19 CMS 372 report and is calculated by dividing the total days of waiver coverage by the total unduplicated number of waiver recipients.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is based on the total estimated cost of ITF Waiver services (Special Instruction) divided by the estimated number of waiver participants. The number of unduplicated participants was calculated by adding a 300-growth factor to the estimated end of the Waiver Year 5 of 5,000. The estimated Waver year 5 is following the same +300 logic based upon the 16-17, 17-18 and 18-19 actual numbers of 3666, 4104 and 4423 respectively. This starts the renewal Year 1 at 5300 with an increase of 300 each year ending with 6500. The Average Units per user was calculated by taking the average LOS of 205 and applying the logic that each user will receive a 3 unit service every week. 205 days is 29.28 weeks. 29.28 weeks multiplied by 3 units calculated to 87.85 units. After rounding the units, 88 is being estimated for each user. Finally, the average cost/unit is currently 28.83 which is part of the state rate table.

Factor D growth is not anticipated, as the average LOS has been relatively stable in the current renewal application and the logic for average units has not changed. The current actuals for years 16-17, 17-18 and 18-19 have remained rather stable as reported so the same stability is anticipated.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is based on the 16-17, 17-18, and 18-19 CMS 372 reports showing varied results from year to year (19263,18217 and 17882 respectively). Rather than projecting a downward trending for Factor D', an average of the three know years was used. The population using the ITF Waiver is everchanging, as children are eligible for only the first 3 years of life. This constantly changes the demographics measured for Factor D' since the AOL is less than 1 year in most cases; making estimates of increase or decreases less valid or reliable.

Medicare Part D costs are not included in the derivation of Factor D'. The Office of Child Development and Early Learning has a process by which figures for the derivation of Factors D, D', G, and G' are obtained from the state's MMIS and PELCIAN-EI data systems in preparation for submission of the CMS 372 report. The review of this information includes the identification of Medicare/Medicaid dual eligible and the removal of any Part D prescribed drug costs from the baseline of Factor D' figures.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on averages from the 16-17, 17-18, and 18-19 CMS 372 reports as the reported amounts varied from year to year increasing and decreasing. The population using the ITF Waiver is everchanging, as children are eligible for only the first 3 years of life. This constantly changes the demographics measured for Factor G; making estimates of increase or decreases less valid or reliable.

This dollar amount is the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted. Due to the variability, an average that will held for the duration of the 5 year application is going to be applied.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on averages from the 16-17, 17-18, and 18-19 CMS 372 reports.

The population using the ITF Waiver is everchanging, as children are eligible for only the first 3 years of life. This constantly changes the demographics measured for Factor G'; making estimates of increase or decreases less valid or reliable.

When the waiver serves children, the G' value includes services required under EPSDT that are not accounted for in the G value. In the case of waiver renewals, the estimate of Factor G' may be based on figures reported via the CMS-372(S) only when the reported CMS-372(S) figures represented actual expenditures. Estimates of Factor G' must not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligible under the provisions of Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Special Instruction	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Instruction Total:						**13446312.00**
Special Instruction	15 minutes	5300	88.00	28.83	**13446312.00**	

GRAND TOTAL:	**13446312.00**
Total Estimated Unduplicated Participants:	**5300**
Factor D (Divide total by number of participants):	**2537.00**
Average Length of Stay on the Waiver:	205

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Instruction Total:						**14207424.00**
Special Instruction	15 minutes	5600	88.00	28.83	**14207424.00**	

GRAND TOTAL:	**14207424.00**
Total Estimated Unduplicated Participants:	**5600**
Factor D (Divide total by number of participants):	**2537.00**
Average Length of Stay on the Waiver:	205

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Instruction Total:						**14968536.00**
Special Instruction	15 minutes	5900	88.00	28.83	**14968536.00**	

GRAND TOTAL:	**14968536.00**
Total Estimated Unduplicated Participants:	**5900**
Factor D (Divide total by number of participants):	**2537.00**
Average Length of Stay on the Waiver:	205

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Instruction Total:						**15729648.00**
Special Instruction	15 minutes	6200	88.00	28.83	**15729648.00**	

GRAND TOTAL:	**15729648.00**
Total Estimated Unduplicated Participants:	**6200**
Factor D (Divide total by number of participants):	**2537.00**
Average Length of Stay on the Waiver:	205

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Instruction Total:						**16490760.00**
Special Instruction	15 minutes	6500	88.00	28.83	**16490760.00**	

GRAND TOTAL:	**16490760.00**
Total Estimated Unduplicated Participants:	**6500**
Factor D (Divide total by number of participants):	**2537.00**
Average Length of Stay on the Waiver:	205